



# THE BRITISH HIP SOCIETY

NEWSLETTER - August 2015

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## INSIDE

**Engage and validate**

John Nolan

**Mix and Match**

John Skinner  
Fares Haddad  
John Nolan

**ACPA at the BHS**  
Mark Goodson

**Developing a  
Revision  
Network**

Andrew Manktelow

**SAP & NJR**  
Dominic Meek

**The Rothman Ranawat  
Travelling Fellowship**

Jason Webb



**Stephen A Jones**

Hon Secretary  
British Hip Society

Dear BHS Member,

Welcome to the 2015 British Hip Society newsletter. We hope that you will enjoy reading this and access the British Hip Society website for more detail.

We would like to highlight the Charnley speaker invited by the British Hip Society to the BOA meeting in Liverpool 15<sup>th</sup>-18<sup>th</sup> September 2015. This will be Prof. Göran Garrellick who will speak on the very topical issue of Registries – what they can and can't tell us about surgeon performance.

We would also like to remind our younger members that the Rothman-Ranawat Travelling Fellowship is open to applications at the moment and these must be submitted before the end of August for interview at the BOA meeting in Liverpool.

There are also some important dates for your diaries. The Combined Italian/British Hip Society meeting in Milan 26<sup>th</sup> & 27<sup>th</sup> November 2015. This meeting will include instructional lectures, free papers, academic and social interaction with our Italian hosts.

The 2016 British Hip Society meeting will be in Norwich with John Nolan as President the confirmed dates are 16<sup>th</sup>-18<sup>th</sup> March.

Yours sincerely,

Stephen A Jones  
Honorary Secretary

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## CONTENTS OF THE 2015 BHS NEWSLETTER

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### INSIDE

Engage and Validate	3
FIPO and Private Practice	5
Mix and Match	6
Development of the Annual BHS Meeting	8
ACPA at the BHS 2015	10
BHS Website & tour of members area	12
Developing a network: The future of revision hip surgery	14
Scottish Arthroplasty Project and National Joint Registry – Nation divided or parallel evolution.	17
NAHR – Update.	21
The Rothman Ranawat Hip Travelling Fellowship	22
Treasurer's Update	26

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# ENGAGE AND VALIDATE !

John Nolan

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**John Nolan**  
**BHS President**

The National Joint Register continues to face a number of challenges and these have been discussed at its Medical Advisory Committee meetings, where I have represented the BHS.

At the NJR MAC we have continued to insist to HQIP, that unit level reporting of outcome data (e.g. revision rates) is the responsible way forward, at least until data completeness and accuracy is assured. Unit level data better reflects the influence of case-mix and the effect of resource limitations over which we as individual surgeons often have little influence.

For those of you who found the Surgeon Level Outcome Session at our recent BHS Annual Scientific Meeting interesting, as well as for those who were unable to attend this part of the meeting, I would urge you to read Issues 4 and 5 of The Royal College of Surgeons of England: Bulletin. The debate continues!

There can be no doubt that the issues of Surgical Outcomes and Transparency are here to stay and will affect us all, increasingly so and regardless of whether or not we are successful in our on-going discussions, the time has come for us all to engage actively in the validation of our own data, going forward.

It is in our interests both individually and as a profession that NRJ data should be accurate. "Advancing Standards and Reducing Variability of Patient Outcomes" is now an established agenda

Individual surgeon level compliance rates are likely to be published this year and you will be invited to validate your own figures by NJR.

Many of you will already have seen your unit level dashboards published by the NJR and work is underway to develop these further with additional indicators.

Along with the BOA and NJR, BHS responded to the HQIP consultation on the Consultant Outcomes Report (COP). The proposed mechanisms (and the language) for identifying "outliers" as well as the proposed response to dealing with them, caused us some concern and required comment and we continue to await a formal reply from HQIP.

At BHS, we remain fully supportive of the transparency agenda whilst married to good quality data.

Martyn Porter (former BHS and BOA president) has taken an informed and considered approach to discussions with HQIP. As part of any "stay of publication" agreement, we will inevitably need to offer an increased engagement in the process of our own individual data validation and this may not be as cumbersome a process as some might think.

Locally, we have initiated two processes.

Firstly, before our monthly departmental data is uploaded to the NJR, our data clerk forwards to each consultant surgeon, the details of cases recorded under their name, by email, for checking. This prospective validation takes about 5 minutes and involves cross checking details against the firm's diary and copies of the month's operating lists. It certainly takes a lot less time than checking large amounts of data retrospectively, as most of the information remains to hand and many of the cases are still familiar.

In an even more straight forward way, some of the database management systems, which are employed routinely to collate surgical data in our orthopaedic departments (e.g. Bluespier) actually allow the surgeon to input the few additional metrics required for completion of the NJR dataset, at the time that the operation note is being produced.

These processes are now being audited locally in the NHS with a view to being extended into the private sector.

Secondly, as others have, we now run 6 monthly "NJR parties". These involve all the hip or knee surgeons in a department meeting for a couple of hours and presenting their recent individual NJR data to the group, explaining anomalies and facilitating discussions about the data within "the unit".

A certificate of participation produced for the purposes of revalidation is a useful additional benefit.

Working together in our provider units, we have an obligation to ensure that all colleagues are practising safely and if we can be seen to be making these processes work, we will have a much greater chance of justifying Unit Level Outcome Data as the preferred option for publication. We are also more likely to persuade our Trusts and other organisations to contribute the necessary resources (time and money) to make the process work.

I would encourage you to reflect on how you might make your own initiatives work locally and to discuss them with others. We can lead on this.

In the meantime, we have made representation to NJR/HQIP for an increased role for BHS on NJR sub-committees including the Editorial, Outlier and Data Quality groups (Peter Howard currently chairs the outlier committee and I have been attending the recent Data Quality meetings).

Last month I attended the International Society of Arthroplasty Registers (ISAR) meeting, held this time at the home of the Swedish Hip Register in Gothenburg, on the occasion of its 40<sup>th</sup> anniversary.

Our Scandinavian colleagues are pressing ahead with PROMS data to inform decision making and predict outcomes and new PROMS metrics are being developed.

Perhaps not surprisingly, issues related to metal-on-metal hip replacements (past and present) continue to arise and are regularly discussed at the Metal on Metal Advisory Group at MHRA where John Skinner and I represent BHS. Those of you still carrying out Birmingham Resurfacing replacements should have seen the Field Safety Notice from Smith and Nephew issued recently.

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## FIPO AND PRIVATE PRACTICE

John Nolan

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The BHS is represented on the FIPO board and an executive member usually attends their meetings in London. The recent focus has been on the appeal against The Competition and Markets Authority Report (CMA) on private practice.

The Judgment is available online but unfortunately, the Competition Appeal Tribunal (CAT) found against FIPO and in favour of the CMA, although perhaps not as categorically as the CMA press release suggests.

In question, was the behavior of the Private Insurance Companies (PMIs) and their increasing practice of fee-capping consultants and "de-recognizing" consultants who charge over their ever-decreasing rates of remuneration for consultation and surgery. FIPO held that this was in itself anti-competitive practice. The CMA had previously indicated that in their opinion it was not and their judgment was being challenged.

The majority 2:1 outcome was notable for the degree to which the economist member opposed the conclusions of the 2 "lawyers". FIPO have been given permission to appeal to the Court of Appeal because of anxieties about factual and economic issues. The CMA will almost certainly mount a counterargument. The case may not be heard for several months.

The dissent from the economist member of the appeals panel is almost unprecedented and leaves the door slightly ajar for further discussion between FIPO and CMA but only really on a goodwill basis.

The so-called Fee Remedy and Information Remedy will now pertain and we will hear more about this over the next few months. We will, it seems, be required to provide all patients with a plethora of information about our possible fees (even though they will essentially be governed by the PMIs!) and divest ourselves of any holdings of more than 5% in facilities and equipment to which we refer patients for investigation or treatment.

The actual details and definitions remain unclear at this stage, as are the possible sanctions and timescales.

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# Mix and Match – An Update

John Skinner, Fares Haddad & John Nolan

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The term Mix and Match describes the use of a combination of implants from different manufacturers, within a single joint replacement and the practice has aroused considerable interest recently.

The term is potentially confusing as it encompasses both **fixed** (trunnion/taper) and **mobile** (head/cup) combinations as well as **hard on soft** and **hard on hard** bearings.

Manufacturers are adamant that companies cannot and will not condone combinations that they have not tested and they will maintain that the surgeon and/or hospital must assume responsibility for the untested construct.

For example, Ceramtec are clear that they will not indemnify a ceramic head from one manufacturer and liner from another, even when both components have been produced by Ceramtec as they insist that the geometry of 12/14 tapers differ.

On the other hand, some components of hip replacements can be considered generic, for example cement and cement restrictors.

Mixing and matching was investigated by the MDA (now MHRA) in the late 1990's and whilst manufacturers considered the practice off-label, the MPS and MDU supported it at the time, if there was good published data.

Mixing and matching of implants might also be considered the least worst option in a **revision** situation, where for example a well fixed un-cemented stem is retained and mated to a head from an alternative manufacturer, a situation that is unlikely to be recommended in the primary situation.

Bio-balls may represent a useful solution here too and whilst there is little evidence as yet, no adverse issues have been reported.

Hard on soft mixing and matching across the mobile articulation of a hip replacement continues to work well with a handful of well-defined implant pairs such as the Exeter stem and Charnley cup, the most successful combination of implants in the NJR.

Likewise, ceramic or ceramicised metal, on polyethylene, should not create significant problems provided sizes are properly matched.

Trunnionosis or tribocorrosion has been highlighted by, but is not limited to, large head metal on metal implants. Where large heads from one manufacturer have been mixed with stems (i.e. trunnions) from another (for example historically, when the head manufacturer did not produce a stem or where the outcomes of mixed components appeared likely to offer better results than matched ones) the results appear, from the evidence available to-date, to have been no worse than matched components and in some cases have fared better. There was little clarity at the time as to what was and was not allowed.

There is still no standard for the stem taper and implant manufacturers continue to use tapers with their own specifications. The geometry, structure and surface finishes differ and two 12/14 tapers may subtend quite different angles depending on the length of each taper, which can vary by several millimetres.

Except in exceptional circumstances, therefore, mixing and matching across the taper/trunnion interface should be avoided. This is particularly so with ceramic heads where the poor fit may lead to fracture of the head. It is likely to prove increasingly difficult to defend the use of mix and match in these circumstances when other options are reasonably available.

The mixing and matching of hard on hard, heads on liners would also appear to represent a risk due to the potential differences in surface geometry, metallurgy and finish.

With the exception of hard on soft mixing and matching across the mobile articulation of a hip replacement, mixing and matching of components should be avoided and where it is still considered the best option, a clear explanation and informed patient consent is highly recommended.

John Skinner

Fares Haddad

John Nolan

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## DEVELOPMENT OF THE ANNUAL SCIENTIFIC MEETING

Andrew Manktelow

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**Andrew Manktelow**  
Editorial Secretary

This year's Annual Scientific Meeting of the British Hip Society in London was well supported and seemed well received. 190 BHS members were among 440 colleagues who attended. Attendance at the meeting is increasing and I hope that this will continue into next year's meeting in Norwich.

The changes introduced in Exeter in 2014 were continued with talks from John Skinner, our past President, detailing his activities during the year and from our President, John Nolan, detailing his expectations and plans for his year in office.

The review of the poster presentations had been popular in Exeter and I hope it was helpful to hear the thoughts of a number of BHS executive colleagues on the key messages from the poster boards again this year. This seems a good way to ensure that important information from the large number of excellent submissions that we are unable to accept for podium presentation is disseminated. In that regard, once again I had shortened the podium slots to increase the proportion of submissions that we are in a position to accept for presentation.

One new item in London was the presentation from the Non-Arthroplasty Hip Registry, detailing its activities and the importance of BHS members playing their part in this exciting project. This is something that we will repeat in Norwich.

Elsewhere, there are a number of challenges in 'timetabling' the meeting. One is the conflict in timetabling the ever-popular Emerging Hip Surgeons Forum at the same time as the British Orthopaedic Research Society (BORS) session. Running these sessions at the same time is not ideal.

The target audience in the Emerging Surgeons Forum is self-explanatory and we hope that colleagues are able to identify which of the sessions they would find most valuable. Some have attended segments of both. Moving forward it may be that we try to avoid that conflict in the future. This conflict also means that all members are not able to hear the BORS presentations within the main meeting. If we are unable to re arrange the timetable and avoid that conflict, we will look to present at least the key messages from the BORS session during the main meeting next year.

Another area of interest that has been discussed within the executive is the introduction of a 'problem solving' or 'complex case presentation' session in the BHS meeting. Whether this would be presented as a voluntary 'break-out' session during one of the lunch breaks or indeed as a session in its own right will be discussed. The concept would be that colleagues submit cases they would wish to present and discuss at the session, chaired by one of the BHS Executive, to a panel of experienced hip surgical colleagues, with the aim to provide advice and evidence based options in management.



Regarding the process by which abstracts are submitted evaluated and selected for presentation at the meeting, again Richard Field and the 'web-site' team have worked extremely hard. We were delighted to receive over 200 submissions in 2015.

The evaluation and subsequent analysis proved very much more straightforward than in previous years. We expect to improve the website further and increase the ease by which submissions can be made and decisions communicated, well before the process starts again for the 2016 meeting in Norwich. In this regard, it is important to re – iterate that it is mandatory that a declaration of interest statement is made at submission, and again by all colleagues who present at the annual meeting.

I am very keen to continue to develop and will endeavour to improve the Annual Scientific Meeting. It is a huge privilege to be in a position to co-ordinate the event. If any colleagues have suggestions or comments on timetabling, content or other additions to the Meeting I would be very happy to discuss them. I can be contacted via the British Hip Society website.

Beyond that I would encourage as many as possible to work on projects that could be presented at the BHS next year and look forward to those submissions. It is always an exciting challenge to put together our BHS Annual Meeting but a challenge I have enjoyed. I look forward to further developments in the programme as we start to co-ordinate the event and timetable for Norwich, under John Nolan's presidency, in 2016.

Andrew Manktelow

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# ACPA at the BHS 2015

Mark Goodson

## Education Secretary – Arthroplasty Care Practitioners

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Put simply this year the ACPA meeting was a high quality event at a high quality venue with high quality speakers. For me (and this was my second meeting) I found the whole conference not only enjoyable but also informative and completely relevant to my practice as a Surgical Care Practitioner. I certainly took away invaluable knowledge that will only help to shape my role and practice in the future. The event was a fitting tribute for ACPA as it celebrated its ten years anniversary. If anyone has not attended this event, at any time, I would urge you to do so.

Professor Tim Briggs was our first speaker who has been visiting orthopaedic centres around England and Wales in order to assess the variation in practice called 'GIRFT' – 'Getting it right first time'. Prof Briggs began with detailing the financial impact of healthcare to the UK economy.

We currently spend 9.3% of our GDP on healthcare, but, in acknowledging this age of austerity, he noted that national debt is increasing. £10 billion is spent annually on musculoskeletal disease and remember our population is getting older. The National Joint Registry records 47000 TKR/THR surgeries in 2004, in 2013 this had increased to 181,000 surgeries. Given the fact that 85% of hospital trusts will be in deficit in 2015 it is clear to us all that reform is needed.

Our second speaker was Dr Ian Gould, a GP practising in Hertfordshire. A well-delivered presentation looked at what happens to patients when they present to their GP with 'hip pain'. 450 per 100,000 present to primary care establishments with hip pain annually.

GPs are required to identify the exact area of pain, a difficult task when patients often present with more than one problem and consultation time is not plentiful. Furthermore, GPs are under pressure to reduce hospital referrals and approximately 90% of conditions are treated within the primary care sector.

Mr Peter Smitham presented a talk on the anatomy of the hip and related pathology, he didn't disappoint and his talk was well received. Andrew Manktelow, Specialist Hip Surgeon at Queens Medical Centre in Nottingham, who presented his talk on an Overview of Differential Diagnosis – If it's not the hip, followed this. His take home message was to be aware of, anything unusual, an atypical location and inconsistent history.

Following lunch Professor Gordon Blunn (UCL) presented an excellent and engaging session on material choices for hip implants. Whilst Prof. Briggs discussed the financial discrepancies between uncemented and cemented prostheses in his earlier talk, Prof. Blunn described why one would choose between options.

Prof. Blunn lastly described 'Trunionosis' which was not only engaging, it contained much useful information and it was relevant to our everyday practice. The committee thank him for his time and interaction with the audience.

The last presentation of the first day came from Harri Hothi from the London Implant Retrieval Centre. One hundred and fifty two orthopaedic surgeons have contributed more than 2000 failed metal-on-metal (MOM) hip components from 60 hospitals and 16 countries.

Day 2 was opened with a talk given by Cathy Millyard (Surgical Care Practitioner – Torbay)

Cathy described the history around her appointment and the appointment of other SCPs in Torbay. What was very apparent from her talk was that we develop our roles in very individual ways in order to meet local requirements and different elements of practice. It was therefore inspiring to hear about Cathy's journey so far and her plans for retirement in the near future. We wish her well with that and thank her for contributing positively to our conference.

Professor Fares Haddad gave the next presentation. As a SCP who consents patients for surgery one issue I stress during this consultation is leg length discrepancy following THR. It was therefore very helpful that Prof. Haddad based his presentation on Leg Length Inequality, prevention and management.

An issue that arises frequently in our clinics is that of Greater Trochanteric Pain or suspected Bursitis. It was therefore very good of Emma Stewart MSK Physiotherapist at Stanmore Hospital to take the time and effort to deliver her excellent high quality presentation on this complex problem. Emma's presentation was not only insightful and as such extremely helpful, our feedback on this presentation echoed comments relating to the high standard of the presentation and the speaker. So, thank you once again on behalf of the committee.

"Often a minefield to understand" was a comment made in relation to the next presentation. Dr Simon Warren from the Royal Free, London gave another excellent presentation to help lift the fog of confusion surrounding the Microbiology Assessment and Treatment of Infected Hip Replacements.

Another mystery subject for us at times is that of CT & MRI interpretation. It was therefore again useful that Dr Michael Khoo, the Royal National Orthopaedic Hospital, was able to deliver his CT & MRI for dummies: pre and post op Classifications of hip Pseudotumours presentation to us.

Dr Khoo was the last guest speaker over the 2 days of our conference. When all the cerebral effort had ceased in respects to listening to our many great speakers we were able to relax and celebrate the success of the 2015 ACPA conference by acknowledging the efforts of the organising team and by celebrating the 10 year anniversary of ACPA by sharing a celebration slice of cake (or 2!!). Jill Pope (ACPA President) confirmed the appointments of Clare-Louise Sandell as Vice President and Myself as Education Secretary. A big thank you to all those who attended and who made it such a successful event.

Mark Goodson

Education Secretary

Arthroplasty Care Practitioners Association

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## BHS Website – A brief tour of the “Members Area”

Richard E Field

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The BHS website is evolving from a noticeboard of society news and information into a resource to support the administration of BHS activities.

Critical to the viability of our society is the need to keep an accurate register of our membership and to ensure that our members stay up to date with payment of their subscriptions. The website now contains a database of BHS members. All BHS members are able to review and edit their personal information as well as check their subscription history. To view and update your BHS entry please follow the link and steps listed below:

<https://www.britishhipsociety.com/login>

This will take you to the BHS website. In the top right corner of the screen you will see login boxes. In the left box please enter your **BHS username**, in the right hand box enter your **BHS password**.

Assuming that you know and have remembered your login information you will now be able to see a set of drop-down tabs when you select the **MEMBER AREA** option at the top of the screen. If you are unable to remember your login information, please email me at [webmaster@britishhipsociety.com](mailto:webmaster@britishhipsociety.com) or [richardefield@aol.com](mailto:richardefield@aol.com).

Please ensure that you state your problem clearly and also provide a telephone number that I can use to call you. We are trying to establish robust, on-line system to support members who have forgotten their **BHS username** and/or **BHS password**.

One of the difficulties that we are experiencing with such support is that many BHS members have multiple email addresses and sometimes forget which one they used for their profile.

To review and update your membership profile please click the **My account** option. There are four separate sub-screens contained under the **My account** heading. These are **Registration Update**, **Subscription Update**, **Fellowships Offered** and **Collaborative Research**.

**Registration Update.** This page shows the demographic information that the BHS keeps about you. The uppermost section of this page relates to your login information. You are able to change both your **username** and your **password**. Please remember to press the blue **Change Password** button so that the database is updated. Also, please record your username and password somewhere safe and accessible.

The second part of this screen has two types of box, grey background or white background. Grey background boxes contain information that you are not able to edit. If any of this information is incorrect, please email the BHS Treasurer (Jonathan Howell) and/or the BHS Secretary (Steve Jones) at [treasurer@britishhipsociety.com](mailto:treasurer@britishhipsociety.com) or [secretary@britishhipsociety.com](mailto:secretary@britishhipsociety.com) respectively. In contrast, we rely on you to keep the information in the white background boxes up to date and accurate. Please check this information at least yearly.

The third section of this page relates to the information that we plan to use to confirm your identity when you contact us with login difficulties. Again, please ensure that one of the questions has been answered and that you have recorded your answer somewhere safe and accessible to you.

**Subscription Update.** This page provides a summary of your BHS subscription history. The uppermost box tells you when your next subscription will be due. The middle section details your subscription payments over the last few years and the last section provides details of the BHS bank account so that you can make your payment on-line. We are in the process of adding a PayPal facility for your subscription, conference, BHS gifts and other society related payments. If you have any problems updating your subscription history or information, please contact the BHS Treasurer (Jonathan Howell) at [treasurer@britishhipsociety.com](mailto:treasurer@britishhipsociety.com) .

**Fellowships Offered.** This page allows you to enter information about any Fellowships that you offer and would like to be advertised on the BHS website. The information that you enter in this section will be reproduced in **Fellowships – UK** page, which can be accessed via the **FELLOWSHIPS** tab on the homepage. Please note we will delete current entries from time-to-time and we request you to update your entries yearly.

**Collaborative Research.** This is a new initiative that we are trialling. All clinicians see patients with a problem that only crops up on a rare or infrequent basis. For example a condition, diagnosis or finding that we might only see a few times in our career. At present, it is next to impossible to find enough cases of the problem to determine its natural history, treatment options and clinical outcomes.

The aim of this section is for BHS members to upload information on rare conditions. If other BHS members have seen the same problem, they can pool their cases and a cohort can be collected for further study. We hope that this innovation will prove helpful and lead to some worthwhile publications by collaborating groups of BHS members.

Finally, I am keen to recruit a team who would be able to play an active role in the further development and validation of the BHS website. If you would like to be a member of this team, please contact me at [richardefield@aol.com](mailto:richardefield@aol.com), [webmaster@britishhipsociety.com](mailto:webmaster@britishhipsociety.com) or 07860403610.

Richard E Field

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## Developing a network: The future of revision hip surgery ?

Andrew Manktelow

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On-going improvements in surgical technique and implant choice coupled with reduced bearing surface wear are expected to improve clinical outcomes in hip arthroplasty. However, with an ever-increasing number of primary total hip replacements being performed in the UK, in an increasingly ageing, yet active population, an increase in the number and complexity of revision procedures is expected.

The potential clinical challenge surrounding revision surgery is well understood. Links between high clinical activity and improved outcomes are established. Similarly, it is appreciated that managing complications following failed surgery is a significant potential drain on clinical and financial resource. NHS England have estimated that if national infection rates could be reduced to that of specialist units of 0.2 per cent this could, in its own right, save the NHS £300 million a year.

In the planning and provision of orthopaedic services, NHS England has advocated the development of specialist orthopaedic networks. With the provision of specialist orthopaedic services delivered, or supervised, by appropriately trained surgeons working in multi-disciplinary teams, based in specialist centres or 'hubs', through networks that will generate high activity, share experience and expertise, and thus disseminate 'best practice'. It has been proposed that this model will, in time, be extended to include the provision of orthopaedic services in the foot and ankle, shoulder, elbow, hand and wrist as well as brachial plexus, peripheral nerve injury and soft tissue sarcoma.

The concept is that it makes clinical and financial sense to concentrate more complex procedures in central 'hubs', allowing multi-disciplinary teams in specialist centres to provide clinical support while continuing to drive innovation. The expectation is that this will improve outcomes, reduce cost and deliver the highest quality specialist care to patients of all ages. The development of the specialist orthopaedic network is also very much in line with Professor Briggs' and the BOA 'Getting It Right First Time' initiative and report.

Against this background, Nottingham Elective Orthopaedic Service (NEOS), as part of Nottingham University Hospitals, NHS Trust, was successful in an application for a CQUIN grant of £250,000 from NHS England to set up a specialist orthopaedic network surrounding hip and knee revision surgery in the East Midlands. The grant was awarded in March 2014 to provide a twelve-month pilot project. An expectation of improved National Joint Registry data submission and a reduced requirement for loan instrumentation was part of the CQUIN funding.

Initially specialist revision surgeons from NUH travelled to surrounding hospitals to meet with relevant Consultant colleagues, to introduce the concept and to seek their involvement and support, which was universally forthcoming. Subsequently, a more formal meeting was held with all hip and knee revision surgeons from Nottingham, Lincoln, Grantham, Boston and King's Mill Hospitals. The Trusts involved provide orthopaedic services to a population of around 4 million people.

During collaborative meetings the clinical criteria for the cases to be discussed were established. Referral protocols and proformas, communication pathways and evaluation mechanisms were developed.

The model established by the group was of a weekly meeting, chaired in Nottingham by surgeons with a specific interest and specialist training in revision hip and knee surgery. The multi-disciplinary group in Nottingham was to include surgeons, a microbiologist and musculoskeletal radiologist. In addition, as and as required there would be access to Plastic, Vascular and General surgical colleagues as well as specialist Anaesthetic support.

The first meeting of the East Midlands Specialist Orthopaedic Network (EMSON) took place in January 2015 and weekly meetings have been held since. A network co-ordinator has been recruited and appointed. Referrals are made by e-mail on a proforma, providing a full and relevant history and details of the investigations to date. The referring Consultant is encouraged to identify planned or potential surgical options.

A major challenge has been the integration of PACS services to allow imaging to be reviewed at multiple sites simultaneously. The Network meeting is hosted via a teleconference facility in Nottingham, with the ability to control PACS images, to be transferred from one hospital to another as cases are presented. While there were 'teething problems' early on, specifically with the coordination and communication between PACS systems in the various hospitals, the meeting has run very smoothly more recently.

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The concept and the network has proved popular with colleagues from all the contributing hospitals. With a collaborative approach, there has been excellent engagement of the vast majority of surgeons who perform hip and knee revision surgery from all of the referring trusts. Independent evaluation of satisfaction within the network has shown high levels of support. Following discussion and reviewing the first 100 cases it has been estimated that a change of management of some type was suggested in around 30 per cent of cases. A small number of cases have been transferred through to Nottingham for surgery though the vast majority have continued to have their surgery performed in the referring hospital, once a management plan has been established and agreed.

In essence, while somewhat of a challenge to establish, it seems that the network is proving popular with the surgeons involved, allowing an evidence based discussion, the dissemination of ideas and practical 'tips and tricks' as well as more formal technical support when required. We would welcome any BHS colleagues to visit if they would like to 'see' the network in action and look forward to updating colleagues with a more formal evaluation in due course.

Andrew Manktelow



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# Scottish Arthroplasty Project and the National Joint Registry -Nation divided or Parallel evolution?

Dominic Meek

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**Dominic Meek**  
BHS Member at Large

## **Scottish Arthroplasty Project (SAP)**

Clinical Governance: “A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.” This was the stimulus for formation of SAP.

SAP started in 1999 and is a clinically lead utilising the Patient Identifiable outcomes - Scottish Morbidity Record (SMR01). It is not an implant “Register” and has minimal “administrative” dataset. Its aim is to identify variation and thus encourage continual improvement through feedback and influence/effect change. It balances the desire to change hopefully for the better with available data. The data used by the SAP comes from SMR01. All NHS Acute Hospitals in Scotland submit an SMR01 record for every inpatient or day-case patient episode.

All SMR01 records are submitted to the Information’s Services Division, NHS Scotland, where they are held on a central database. SAP data is automatically collected with no consent required from patient. (Fig 1) This data is held under the strict confidentiality guidelines that were laid down by the Data Protection Act of 2000.

## **SAP Measures for Improvement**

SAP monitors the clinical outcomes of hip and knee replacement patients following surgery. Basic data set is age, sex, disease (e.g. Rheumatoid), social deprivation, residence, operation, re-operation, re-admission with, surgeon and death. The complication rates associated with the surgeon being measured are:

- Dislocation of the hip joint within 365 days of surgery
- Infection of the joint within 365 days of surgery
- VTE within 90 days of surgery
- Death within 90 days of surgery
- Early revision of prosthesis (within 3 years)

Accuracy of data capture is approximately 95%. In addition, anaesthetic associated rates are recorded for Myocardial Infarct, Renal Failure and CVA

The latest advance for SAP has been the electronic linkage of the national theatre system to download implant and selected theatre data including the surgeon electronically every week. Having being successfully trialled in Aberdeen it is possible it may be rolled out across the Scottish trusts.

## **National Joint Registry - NJR**

The NJR was set up in 2002 by the Department of Health. The establishment of the NJR for England and Wales was made in response to the Royal College of Surgeons report on the 3M Capital hip. The report highlighted the need to compare the performance of the 3M Capital hip against other types of hip replacement. The limited comparisons that were made suggested the 3M Capital hip's poorer performance would have been more readily apparent had data on implantation and revision been systematically collected and analysed.

The NJR collects data after consent is obtained, the principal difference to SAP is that implant data is collected and from 2010 PROMS data also collected. The Welsh Government and Northern Ireland joined the NJR in 2013. The NJR currently collects data on all hip, knee, ankle, elbow and shoulder joint replacements across the NHS and independent healthcare sector.

### **NJR mission statement**

'The purpose of the National Joint Registry for England, Wales and Northern Ireland is to collect high quality and relevant data about joint replacement surgery in order to provide an early warning of issues relating to patient safety. In a continuous drive to improve the quality of outcomes and ensure the quality and cost effectiveness of joint replacement surgery, the NJR will monitor and report on outcomes, and support and enable related research.'

Up until April 2014, the NJR was funded through a levy raised on the sale of hip, knee, ankle, elbow and shoulder implants. From April 2014, the NJR is funded through a subscription service where payments from NHS and independent providers of joint replacement surgery are based on the volume of procedures carried out across orthopaedic surgery providers.

The SAP is funded by the Scottish government directly and is relatively cost effective at approximately £60,000 per year.

## **NJR Patient Reported Outcome Measures**

Currently, all NHS patients who are having hip or knee replacements, varicose vein surgery or groin hernia surgery are being invited to fill in Patient Reported Outcome Measures (PROMs) questionnaires as part of the Department of Health's PROMs programme. The NHS asks patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards at six months. This programme is part of the NHS measuring and improving the quality of its care.

Combining these 'patient outcomes' with the 'clinical outcomes' data from the NJR will give a more comprehensive picture of the outcome of operations.

## **Extending National PROMs**

The NJR has undertaken a project that will extend the PROMs follow-up in order to help surgeons better understand the influences behind the success of joint replacement in the long term.

The aim of the NJR's extension of PROMs is to provide data that will allow surgeons to understand what influences the success rate of operations from a patient's perspective. The longer-term goal is to look at PROMs as a predictor for failure. It is hoped this will feed into continued improvements in the treatment of patients. This extended data will provide the largest and most comprehensive assessment of the long-term consequences of hip and knee joint replacements and their determinants in England and Wales.

Unfortunately SAP does not as yet record PROMS, which is principally down to funding issues but hopefully may be addressed in the future. SAP is however very sensitive to picking up complications and does not rely on reporting problems such as under recording of revisions.

From 2003 to 2009, Shewhart control chart methodology was used to present SAP complication data and identify any unusual variation. In the control chart, the 5-year aggregated outcomes for NHS Boards or Consultants were case mix-adjusted and plotted in relation to three standard deviations above and below the mean.

If an NHS Board or Consultant was outside this statistical limit they were identified as outliers, and our Clinical Governance remit required that we provide them with this information and asked that they review their complications. From 2010 SAP started using CUSUM methodology to allow us to identify unusual runs of complications more quickly. Subsequently health boards using poorly performing metal on metal implants were picked up very quickly despite no implant record and local audit identified the prosthesis involved.

### **Outlier and Feedback Process**

With regard to SAP, when outliers are identified, NHS Boards and Consultants are asked to undertake local reviews that investigate the reasons for these results and report back to SAP. This may identify the introduction of a new technique, a new implant or particular case mix issues.

The Scottish Arthroplasty Steering Committee (SASC) grades responses as Exemplary, Excellent, Satisfactory or Less than satisfactory, and provides feedback.

If the response is unsatisfactory, a resubmission addressing any discrepancy is requested. (Fig 2) The SAP analysts throughout administer this process so that outliers are not identifiable by members of SASC. SAP continues to monitor performance and will contact outliers again if complication rates remain unusually high. The purpose of reviewing outliers is to emphasise quality improvement, and not to attribute blame, as it is possible the data may be suspect. The aim of the review process is to continue to encourage local review of clinical practice and data quality, both of which contribute to the continual improvement of patient care.

A similar mechanism exists for the management of NJR outliers. Written notification to the consultant and their line managers is undertaken to outline that there is deviation from the 'norm' and requesting data validation and a response. It then becomes a similar issue between the Trust and their consultant to investigate and act appropriately on this.

In general the consultant body has embraced these feedbacks positively and used them as evidence for appraisal and revalidation and generally support the process

### **Outlier comments**

“Gives the surgeon insight”.

“Useful for appraisal”.

“Good method for highlighting problems”.

“Identifies performance relative to others”.

“Should be applied to all areas of practice”.

“Use the data in the consent process with patients.”

## Consultant Outcome Publication

SAP does not publish consultant outcomes and there is no intention at present to change this. If the SAP has a freedom of information act application then individual results are protected if SAP demonstrates benefit for the community, as therefore there would be no benefit for the information to be divulged. This is the case with year upon year of constant reduction in dislocation rate, infection and numbers of low volume surgeons. This demonstrates the use of local audit results in a process of constant improvement without individual consultant publication.

However, in England and Wales the NJR has recently been obliged by government to contribute to Consultant Outcomes Publication for mortality data. From recent BHS attendance at NJR MAC meetings, it is apparent there is continuing political pressure for surgeon level data on revision rates. There is concern this will lead onto revision rate league tables. The BOA and NJR stance continues to stress the importance of unit level data. Data validation remains an on-going concern and NJR await the outcome of a legal perspective if challenged on this.

The London Implant Retrieval Centre, examining NJR entries on retrieved implants, has highlighted the inaccuracies present in the NJR dataset. At the 2015 BHS meeting a database error of 16% and more recently at the 2015 London Hip Meeting further data where only 40% of retrieved implants were registered on NJR. Therefore potentially 60% of that cohort of revisions is not contributing to revision funnel plots. The implications of this to individual surgeons can be dramatic.

## Conclusion

As a society the BHS would hope to maintain feedback of data to consultants in a non-confrontational way and emphasize the benefits of unit level data to stimulate in-house validation audit exercises. This is by far the best way to benefit the patient. Publication of raw unadjusted data with mortalities league tables at the individual consultant level would be a retrospective step. The purpose of national audits is to benefit patients by identifying problems that can be dealt with locally and flagging up failing implants.

Hopefully, the BHS will be able to convince the respective CMO and appropriate government bodies that naming and shaming is not the way forward in a progressive society.

Dominic Meek

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# NON ARTHROPLASTY HIP REGISTRY UPDATE

Marcus Bankes

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The Non-Arthroplasty Hip Registry continues to develop and the data set and data entry portal are now mature, particularly with the addition of cartilage damage fields for both the acetabulum and femoral head.

Whilst there has been a steady increase of both surgeons and patients using the Registry, more work needs to be done. We must also remember that it took ten years for the NJR to become embedded in daily practice, although it must not take as long as that for the NAHR. The user group has various strategies to involve more units and is currently actively fund raising from Industry in order to provide funds to promote the Registry both for hospitals and patients. We envisage visiting both known high volume units in both the public and private sectors to assist with their data entry process as well as help existing users to further fine-tune and embed their activity.

Support from BHS members to encourage their hip preserving colleagues to submit data to the NAHR is essential; the process is deliberately very similar to that of the NJR. Other strategies to improve uptake involve making registry submission part of Best Practice Tariff for hip preservation surgery and a requirement of insurance companies.

Funding will also allow specific development of automatic appraisal style reports, an Annual Report, statistical support and data validation.

The NAHR is also an important part of the Quality Outcomes Committee at the BOA coordinated by Julia Trusler (Quality Outcomes in Orthopaedics Programme Director) and chaired by Colin Howie. This is an umbrella organisation to share knowledge and experience with the other non-NJR Registries such as the National Ligament Registry and the British Spine Registry. Thus far it has been particularly helpful in technical areas such as contracts, data protection, and insurance, although the role of this group will continue to develop.

It is important users remember that there is technical support available from Amplitude, particularly when patients are having trouble accessing their follow-up forms. Amplitude are very keen to ensure the NAHR runs smoothly and support is generally helpful and agile in my experience.

If you need any help or support using the registry, please ensure you call the support team on 0333 014 6363 or email [customer.support@amplitude-clinical.com](mailto:customer.support@amplitude-clinical.com).

Finally I would like to thank the User Group, namely John Timperley, Tim Board, Max Fehily, Tony Andrade, Matt Wilson and Paul Gaston, whose enthusiasm continues to drive this essential project forward.

Marcus J K Bankes  
Chair, NAHR User Group



# THE ROTHMAN RANAWAT AMERICAN HIP SOCIETY TRAVELLING FELLOWSHIP 2015

Jason C J Webb

I write this report of the Rothman-Ranawat Travelling Fellowship after being back in the UK for 6 weeks (the same duration as the fellowship itself) and I still feel a great number emotions associated with it.

Despite researching the country, culture and surgeons in advance, I was not prepared for the impact that the fellowship has had upon me. Hip Surgery in the USA, as demonstrated in the top centres selected to host us this year, remains the premier Orthopaedic Sub-specialty. Inhabited by characters that demonstrate enthusiasm, innovation, kindness, generosity, philanthropy and business acumen. I have learnt more about teamwork and efficiency in 6 weeks than in my 7 years as an NHS consultant. Yet the most enduring feelings are of fellowship with my three companion surgeons and of hope to continued collaborations with the host centres.

To detail; one applies for the post via the British Hip Society – we are privileged to have permanent place on the fellowship. You undergo an interview and if chosen you are referred for assessment by the Hip Society (they omit the ‘American’). The administrative staff of the Hip Society (Olga and Lisa) at the Hip Society arrange everything for you.

Three other surgeons are chosen from around the world to become your fellows. This time two Americans and one Irish. All of us, hip arthroplasty surgeons in practice for between 4 and 8 years. The other fellows were Eoin Sheehan from Tullamore, Ireland; Brian Curtin from OrthoCarolina, Charlotte, and Daniel Oakes, from University of Southern California.

I must touch on philanthropy at this stage. Firstly the 102 members of the Hip Society fund the fellowship. The fellowship is named after Dr Chit Ranawat and Dr Richard Rothman, each of whom have donated the most significantly to its running. As you travel around the host centres you encounter private philanthropy supporting most of the units and in particular their research endeavours. The depth of wealth in the USA and its use for good is evident throughout the tour. In contrast however many you encounter, question the rectitude of a public health care system such as the NHS. I still find this paradox confusing.



I saw research performed in all types of institution and found all the surgeons we met to be knowledgeable, erudite and up to date with current hip surgery research. Eoin and myself were chosen as fellows, owing to our research and practice in prosthetic joint infection and this subject generated the greatest amount of discussion at the academic conferences in each centre.

The opportunity to travel ten of the top centres in the USA and be hosted and truly welcomed by the biggest names in the business is a unique experience



The fellowship has an extremely high status in the USA and it is expected that the recipients will go on to contribute significantly in the field of hip surgery. The experience definitely inspired us to work towards this goal. To illustrate why I will now detail the itinerary. The beginning: The American Academy of Orthopaedic Surgeons, Las Vegas Hip Specialty day then introduction to the Society and the other fellows at the Annual Dinner. This was hosted in a rooftop restaurant hotel off the strip that afforded the best way to view Vegas – from a distance. We were introduced to many of the members of the Hip Society that we would encounter again on our travels, including the man most directly responsible for setting up the fellowship, Dr Adolph Lombardi. We would learn that this hospitality and welcome would be repeated for the next five weeks. The next day we flew to the first centre, Stanford University, San Francisco.

Our tour began in Stanford University and Palo Alto San Francisco. We were hosted by Dr Bill Maloney and his colleagues Dr's 'Hutch' Huddleston, Derek Amantullah, Nick Giori, Stuart Goodman and Steve Woolson. After a tour of Stanford University we settled into the fellowship proper. We observed complex hip surgeries in the operating rooms of the university hospital followed by a lively interactive grand rounds with residents and fellows.

We were treated to an excellent steak dinner (the first of many!) with all the attendings, and after much debate on the various facets of arthroplasty surgery we were treated to the hilarious jokes and stories of Steve Woolson!!

University of Southern California, Keck Medical, California

Having left Stanford we arrived in the leafy suburbs of Pasadena California to meet our new hosts in Keck Medical Centre, University of Southern California. This was Dan's home turf so we had a natural chaperone around the campus. We were royally hosted by the great man from "Iowa" Larry Dorr. We observed Paul Gilbert and Larry Dorr demonstrating a master class in robotic arthroplasty surgery. Jay Lieberman hosted an interactive and stimulating academic session where we discussed many of the current issues facing arthroplasty practice, we were joined by Dr Ebramzadeh who enlightened us on modern biomechanics. Many thanks to Jeri for orchestrating the LA visit as well as the hot Mexican food!! After some sunshine and 'Moscow-mules' we left on the 'red-eye' to Philadelphia.

Rothman Institute, Thomas Jefferson, Philadelphia. We arrived on the East coast and were immediately immersed in the efficiencies of the Rothman Institute in the Operating rooms of Thomas Jefferson University Hospital. After observing Drs Hozack and Austin we were treated to a 'sushi' meal by our organising host Greg Dermingian. Sushi beats steak when you have had it 4 nights in a row!! We were entertained and enlightened by Drs Parvizi, Dermingian brothers, Loner, Chen, Austin. The following day we observed Drs Purtill and Parvizi and afterwards were treated to a tour of the Rothman Research Institute. That night we were treated to a superb dinner party by Dr Richard Rothman and his wife Marsha in their home. The conversation was eclectic and philosophical and we finished off the evening with some fine whiskey with the great 'raconteur' Pete Sharkey!!

## Hospital for Special Surgery, New York.

An early start had us on our way to NY City and to HSS. We were hosted by Drs Chit Ranawat and Doug Padgett. After experiencing fine Italian dining with Doug and Amar Ranawat we were immersed in the HSS Operating rooms the following day. We were given open access to all the arthroplasty cases for the day and observed Drs Ranawat, Figgi, Bostrom, Pellicci, Salvati. We participated in a full and educational grand rounds with all the residents and fellows the following morning.

We then met the research team under the guidance of Timothy Wright, we were shown all the simulator and retrieval work currently ongoing in HSS. We were treated to a “tour-de-force of MRI and Mavric sequencing by Holles Potter. The scientific research in HSS was impressive.

Dr Ranawat entertained us the following evening with his anecdotes and imparted his pearls of wisdom to guide us on our professional journey. We even managed to catch a Broadway show before we departed to our next port of call.

## Joint Implant Surgeons, New Albany, Ohio.

An early start from NY had us alighted outside arrivals in Columbus, Ohio. We were met by the ‘Italian dynamo’ himself Dr Adolf Lombardi. We were whisked in style to meet his co-hosts in Italian pedigree machines. Possibly the best way to arrive anywhere!!

Our hosts had organised an afternoon meeting with a varied invited faculty from every corner of Ohio. The following day we witnessed the New Albany efficiency in the operating room with Drs Lombardi, Hurst, Berend and Morris.



We were treated to a variety of Direct Anterior approaches as well as revisions, conversions and difficult primaries. The afternoon was spent discussing cases in a frank and enlightened environment and the day was truly crowned with a delicious home-cooked meal courtesy of Anne Lombardi and the New Albany bonhomie of Dr Lombardi and his colleagues.

## Anderson Clinic, Alexandria, VA.

Over half way through our quest had us arriving Alexandria. We got a chance to explore this historic city before meeting our excellent hosts, namely Drs Engh, Hamilton, Fricka and Goyal, at dinner, The following day we observed a selection of surgical cases including direct anterior approaches and revision for periprosthetic fractures. This was followed by complex cases discussions and a tour of the implant retrieval laboratory. The second clinical day had us participating in a academic conference that also allowed the Anderson Clinic and their neighbours to present papers on subjects such including ‘day case hip arthroplasty’. Watching the ‘Nationals’ play and taking a Segway tour of the Capitol, with the faculty and fellows, were amongst the social highlights of the visit.



Rush University, Chicago.

The penultimate week saw us arrive in the windy city on a rainy afternoon. However the opulent Langham hotel and warm welcome of our hosts more than made up for the temporary dip in the weather. The first clinical day including observing cases at Rush performed by Prof Della Valle, and Drs Berger and Rosenberg. This was followed by an academic conference with the faculty including discussions on the treatment of PJI with Prof Della Valle and metal ion monitoring with Dr Jacobs. The second day was hosted by Drs Paprosky and Sporer at Central DuPage Hospital. We observed complex revision surgery and enjoyed an excellent academic session comprising lectures, clinical cases and comedy.

OrthoCarolina, Charlotte, NC

At a centre of one of our number we experienced Southern hospitality and observed the benefits of working in a unit where team-working has been perfected. We observed a good variety of revision and primary surgical cases using the posterior and anterior approaches. The second day comprised a teaching conference attended by Drs Fehring, Griffin, Mason and Masonis and the departmental fellows. Lively discussion ensued on many subjects and clinical cases. We were made to feel extremely welcome at our hosts' homes and we will not forget the awesome game of 'corn-hole' nor the thrill of white-water rafting.

Massachusetts General Hospital, Boston, MA.

From the outset, our visit to Boston was an educational revelation. Professor Rubash hosted our time at MGH including a tour of the academic department, lunch with Dr Harris and taking part in a conference at the historic Etherdome

The surgical observation took place throughout the city. The Harvard Club, offered a grand venue for dinner with the faculty including Drs McCarthy and Murphy. A tour of Boston allowed us to show off our Segway skills. We also got to watch a Red Sox game at the famous Fenway Park.

London Health Sciences Center, London, Ontario.

The final leg of our fellowship saw us travel to Canada. Steve MacDonald ensured we enjoyed all aspects of our visit to London Ontario, including a tour of the Labatt's brewery. Two days of clinical activity followed with observation of revision hip cases selected for our visit. In addition we toured the research department and took part in two academic conferences with the faculty including Drs McAuley, Howard, Vasarhelyi and Lanting.

The whole experience has been a professional revelation for the four of us. Witnessing the benefits of team-work, organisation and the application of sound scientific principles to improve the outcome of hip arthroplasty surgery has fuelled us to improve the practices in our own units and countries. Forming such professional and friendly ties, can we hope only prove beneficial for the future of Hip Surgery.

Without a doubt an unbelievable experience well worth the time away from family and practice but as you would expect difficult at times. If considering the opportunity all I can say is you will not regret the experience and your practice will absolutely benefit from the knowledge, professional relationships, and new perspectives gained.

Jason Webb

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# BRITISH HIP SOCIETY – TREASURES UPDATE

Jonathan Howell

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## **1. Financial audit 2014**

The BHS finances have been audited by Crowe Clark Whitehill LLP, under arrangements made through the British Orthopaedic Association (BOA.) The audit results may be read in the BOA Annual Report and Accounts, page 27, Note 2.

## **2. BHS Annual Meetings**

The cost of staging BHS 2015 in central London was higher than for previous meetings, resulting in a deficit of £31,802.27.

The projected profit for the BHS meeting in Norwich is for a surplus of approximately £30,000, but this will depend on attendance. The costs of the meetings are fixed but attendance does vary, depending on location in the country.

A proposal to include the cost of the meeting in the annual subscription fee was discussed at the AGM. Views for and against were discussed. It was not felt appropriate to proceed to a vote on this issue, but this may be considered for the 2016 AGM

The Executive will explore additional funding streams for the annual meetings through the coming year.

## **3. Membership subscriptions**

Failure of members to pay the correct subscription remains a problem for the BHS. At present only 294/415 (59%) of registered members pay the correct annual fee. In December 2014 the Treasurer wrote to all members who are in arrears requesting that members pay the correct fee. It was agreed at AGM 2014 that failure to pay three months after a reminder was sent will result in withdrawal of membership.

It was agreed at the AGM that all members who have not paid correct subscription by the end of March 2015 would have their membership withdrawn.

Changes to the website are underway that will allow members to access details of their subscriptions through the "My Account" field.

Jonathan Howell

# INTERNATIONAL COMBINED MEETING VISIT WEBSITE FOR FURTHER INFORMATION

<http://www.sidabhs-jointhip.com>

**BRITISH HIP SOCIETY**

**INTERNATIONAL COMBINED MEETING**

**BRITISH HIP SOCIETY**

**SOCIETÀ ITALIANA DELL'ANCA**

**26-27 NOVEMBER 2015**

**MILAN, ITALY**

**Chairmen**  
Luigi Zagra  
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